ARIZONA DEPARTMENT OF HEALTH SERVICES
CHILDREN'S REHABILITATIVE SERVICES (CRS)

Please send this form to the clinic nearest you:

124 W. Thomas Rd., Phoenix, AZ 85013 T-(602) 406-6446 or Fx-(602) 406-7166
2600 N. Wyatt Dr., Tucson, AZ 85712 T-(520) 324-5437 or Fx-(520) 324-3084
1200 N. Beaver, Flagstaff, AZ 86001 T-(520) 773-2054 or Fx-(520) 773-2286
2400 Avenue A, Yuma, AZ 85364 T-(520) 344-7095 or Fx-(520) 344-7497

CRS APPLICATION FORM

TODAY'S DATE:

CHILD'S NAME (Last, First, Middle)	SEX	DATE OF BIRTH (mo/day/yr) / /
CHILD'S PEDIATRICIAN/DOCTOR ADDRESS		PHONE NUMBER
PARENT OR GUARDIAN (Last Name, First Name)		RELATIONSHIP TO CHILD
CHILD'S ADDRESS street city state zip code county		

HOME TELEPHONE ( ) -	MESSAGE TELEPHONE NUMBER ( ) -	WORK TELEPHONE NUMBER ( ) -	E-MAIL ADDRESS

IN EMERGENCY NOTIFY (name, relationship, address, telephone)

REASON FOR REFERRAL TO CRS

LIST PRIMARY DIAGNOSES (e.g., Cleft Lip, VSD, Cerebral Palsy, etc.) IF AVAILABLE, PLEASE SEND RECORDS WITH THIS FORM.

1) 4)

2) 5)

3) 6)

HAS CHILD RECEIVED CRS SERVICES BEFORE?: YEAR? WHERE?
□ YES □ NO

NAME OF PERSON WHO COMPLETED THIS FORM ADDRESS	TELEPHONE ( ) –	RELATIONSHIP TO PATIENT

REFERRED BY (name,address,telephone) (This individual verifies that the child's parent/guardian has been notified about this referral.)

( ) –

PERMISSION TO OBTAIN RECORDS ***AHCCCS ID #**_____

I hereby authorize and request the CHILDREN'S REHABILITATIVE SERVICES through the authorized contractors, to request and obtain photocopies of medical records concerning the above named patient:

Obtain records from:
Primary Care MD: _____ Address: _____

Specialist: _____ Address: _____

Specialist: _____ Address: _____

Therapist/Education: _____ Address: _____

This consent will expire one year after the signed date below. I have given my consent freely, voluntarily and without coercion. I may revoke this authorization at any time providing I notify the Children's Rehabilitative Services clinic in writing to that effect. I understand that a photocopy or facsimile of this authorization is considered acceptable in lieu of the original.

_____ _____
Signature of Consenting Party Date Relationship to Patient

Please include copy of insurance information or card.

FOR CRS CLINIC USE ONLY			
APPLICATION REVIEWED BY:	DATE	□ Approved	
CLINIC ASSIGNMENTS:			
□ PEND-diagnostic tests	□ PEND-other medical records	□ DENY-no medical documentation	□ DENY-not medically eligible